

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

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World Health Day 1992

The theme for World Health Day, April 7, 1992, is "Heartbeat, the Rhythm of Health." Cosponsors for World Health Day are the World Health Organization, the Pan American Health Organization, the American Association of World Health, and the U.S. Department of Health and Human Services.

This issue of *MMWR* focuses on international health and comprises reports about an assessment of attitudes of parents of high school students in Rome, Italy, about sex, drug, and acquired immunodeficiency syndrome education in schools; the seroprevalence of human T-lymphotropic virus type II among the Guaymi Indians of Panama; and a health information database from the World Health Organization.

Attitudes of Parents of High School Students about AIDS, Drug, and Sex Education in Schools – Rome, Italy, 1991

As of December 31, 1991, the number of acquired immunodeficiency syndrome (AIDS) cases in Italy exceeded 11,500; two thirds occurred among injecting-drug users (IDUs), and 7% occurred through heterosexual contact with persons who were human immunodeficiency virus (HIV)-antibody-positive. In Italy, because the average age at diagnosis among IDUs and heterosexual persons with AIDS has been 28 and 32 years, respectively, many may have contracted HIV infection as adolescents or young adults. To determine parents' attitudes about AIDS, drug, and sex education and parents' role in educating their children about AIDS, Italy's National Institute of Health conducted a survey of parents of high school students in Rome. This report summarizes survey findings and recommendations for the introduction of AIDS, drug, and sex education in Italian schools.

Epidemiologists from 14 of Italy's 21 regions surveyed parents of 725 students from 30 schools chosen by a cluster sample technique of the 292 classical, scientific, and technical high schools in Rome. Staff visited the schools and selected students using a list of random numbers based on the school's size. Each of the selected students was given a letter addressed to the parents explaining the goals of the study and when they would be contacted. The 725 homes were telephoned; 625 (86%) were successfully contacted, and 611 (98%) parents were interviewed. The parent who answered the phone was interviewed; if another family member answered the phone, the interviewer asked for either parent. Most (72%) of the

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respondents were women. Respondents' average age was 44.3 years (range: 30–72 years), and they had an average of two children (range: 1–9); the average age of respondents' children was 16.3 years (range: 13–22 years). Nearly half (49%) had more than a middle school education; 10% had more than a high school education. Using a close-ended, pretested questionnaire, parents were asked whether they had discussed AIDS, drugs, and sex with their adolescents; respondents were also asked questions regarding their attitudes about the introduction of these topics in school. Parents favoring such education were asked at what age the topic should be introduced, what subject areas should be covered, and who should teach them.

Of the 611 parents interviewed, 583 (95%) had talked about drugs with their adolescents; fewer had talked about AIDS (508 [83%]) and sex (460 [75%]). Most believed these topics should be introduced in school (602 [99%] supported AIDS education; 600 [98%], drug education; and 578 [95%], sex education). In addition, when asked whether parents would allow their adolescents to participate, almost all would allow participation (577 [94%] for AIDS education, 571 [93%] for drug education, and 557 [91%] for sex education).

Parents who supported AIDS, drug, and sex education in school indicated that, on average, AIDS education for children should begin at 11.7 years of age, and drug and sex education should begin at 9.2 and 10.2 years of age, respectively. Respondents also indicated that the course content should be relatively explicit: 573 (95%) indicated that the use of condoms should be discussed as part of AIDS education. The persons indicated as most appropriate to teach AIDS, drug, and sex education in school differed by topic. Parents indicated that physicians (384 [64%]) were the most appropriate persons to teach AIDS education, followed by teachers (122 [20%]), and persons with AIDS (37 [6%]). For drug education, parents indicated that teachers (251 [42%]), physicians (164 [27%]), and former drug users (100 [17%]) were the most appropriate instructors. Parents preferred physicians (301 [52%]), teachers (196 [34%]), and themselves (38 [7%]) to teach their adolescents sex education.

Factors associated with parental opposition to AIDS, drug, and sex education in school varied by topic. Parents whose children attended a scientific or classical high school, parents who were aged >45 years, parents who had more than a middle school education, and parents who had never discussed the topics at home with their children were more likely to oppose introducing these topics in school. However, among these four groups, parental opposition did not exceed 8% (range: 1.4%–7.4%).

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Editorial Note: In Italy, the Ministry of Health and the Ministry of Public Instruction developed a series of guidelines (1) similar to those in the United States (2) to assist schools with AIDS education. Several attempts have been initiated to increase the role of schools in education about HIV-infection prevention; however, educators were

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concerned about possible parental opposition to the introduction of AIDS, drug, and sex education in the classroom.

A study conducted in 1989 among high school students in Rome demonstrated a high percentage of students were not correctly informed about the ways HIV can be transmitted (3). One fourth of these students were sexually active; however, most of these students did not consistently use condoms. Other surveys of high school students in Rome have indicated a substantial lack of knowledge about sexual physiology and methods of contraception (S. Donati, National Institute of Health, Italy, unpublished data, 1992); 33% of the adolescents aged 17–20 years did not know when in the menstrual cycle a woman was most likely to become pregnant, and 10% believed that “the pill,” diaphragm, or intrauterine device were better than condoms for the prevention of sexually transmitted diseases.

Findings from the survey reported here suggest that the concerns of school authorities about parental opposition to AIDS, drug, and sex education in Rome schools may be unfounded. Furthermore, many of the parents had discussed AIDS, drugs, and sex with their children. Based on a comparison of these findings with a recent U.S. survey, Italian parents may discuss AIDS with their children more often than do U.S. parents (84% versus 62%) (4).

Because of the unexpectedly low number of respondents in the sample who opposed the introduction of AIDS, drug, and sex education in schools, this study was unable to identify statistically significant characteristic differences that predicted opposition among parents. Parental opposition may be linked to their belief that they had adequately educated their children in the home or that their children were not at risk for AIDS, drug use, or early initiation of sexual activity.

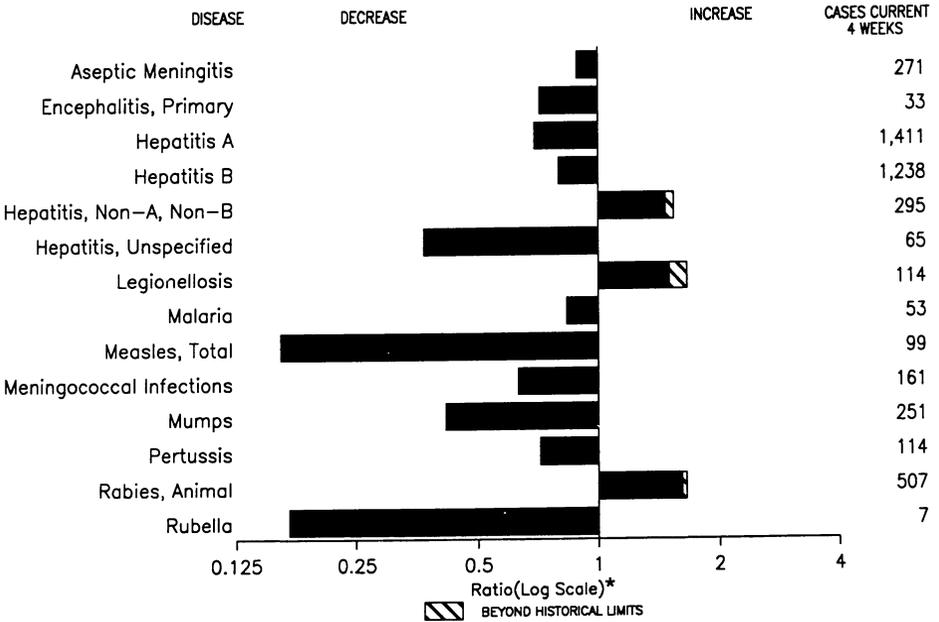
Parents in Rome overwhelmingly supported AIDS, drug, and sex education and indicated that instruction should begin for children before the age when risk behaviors usually begin. The study also revealed that a high number of parents favored explicit information, specifically about condom use. Condoms had not been explicitly mentioned through electronic media until Italy’s 1991 national AIDS television campaign, and the findings in this report suggest a greater openness to deal with such topics among parents of high school students in Rome.

The results of this survey were provided to school administrators and public health practitioners to assist in planning and operating successful AIDS, drug, and sex education programs. In addition, some epidemiologists involved in this survey intend to repeat the survey in their separate regions to assist in the development of appropriate teaching materials and curricula throughout Italy.

References

1. Mixed Working Group of the Ministry of Health/the Ministry of Public Instruction. School guidelines for educational programs in health and the prevention of HIV infection [Italian]. Rome: National Institute of Health, Italy, 1992. (ISSN 0391-1675).
2. CDC. Guidelines for effective school health education to prevent the spread of AIDS. *MMWR* 1988;37(no. S-2).
3. CDC. AIDS-related knowledge and behaviors among teenagers—Italy, 1990. *MMWR* 1991;40: 214–5,221.
4. CDC. Characteristics of parents who discuss AIDS with their children—United States, 1989. *MMWR* 1991;40:789–91.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending March 21, 1992, with historical data – United States



*Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary – cases of specified notifiable diseases, United States, cumulative, week ending March 21, 1992 (12th Week)

	Cum. 1992		Cum. 1992
AIDS	11,470	Measles: imported	28
Anthrax	-	indigenous	213
Botulism: Foodborne	7	Plague	-
Infant	13	Poliomyelitis, Paralytic*	-
Other	-	Psittacosis	11
Brucellosis	3	Rabies, human	-
Cholera	14	Syphilis, primary & secondary	7,878
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year	-
Diphtheria	1	Tetanus	4
Encephalitis, post-infectious	21	Toxic shock syndrome	64
Gonorrhea	111,772	Trichinosis	2
<i>Haemophilus influenzae</i> (invasive disease)	380	Tuberculosis	3,688
Hansen Disease	22	Tularemia	15
Leptospirosis	7	Typhoid fever	58
Lyme Disease	869	Typhus fever, tickborne (RMSF)	23

*Nine suspected cases of poliomyelitis were reported in 1991; 4 of the 8 suspected cases in 1990 were confirmed, and all were vaccine associated.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending March 21, 1992, and March 23, 1991 (12th Week)

Reporting Area	AIDS	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
			Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992		
UNITED STATES	11,470	966	105	21	111,772	128,622	3,712	3,090	744	135	285	869
NEW ENGLAND	410	82	8	-	2,475	3,645	158	147	17	17	21	53
Maine	13	6	-	-	28	21	17	8	2	-	2	-
N.H.	12	4	2	-	-	72	12	11	3	-	3	4
Vt.	-	3	1	-	4	14	1	2	1	-	1	1
Mass.	247	26	5	-	914	1,439	80	101	8	17	10	13
R.I.	14	43	-	-	197	249	33	12	3	-	5	24
Conn.	124	-	-	-	1,332	1,850	15	13	-	-	-	11
MID. ATLANTIC	2,453	129	6	3	8,103	16,525	341	471	101	6	92	696
Upstate N.Y.	436	47	-	-	854	2,590	103	96	63	2	39	489
N.Y. City	1,228	18	-	-	2,963	6,330	69	35	1	-	-	-
N.J.	516	4	-	-	673	2,598	62	137	27	-	16	74
Pa.	273	60	6	3	3,613	5,007	107	203	10	4	37	133
E.N. CENTRAL	1,032	139	32	3	18,011	21,847	455	404	45	7	57	21
Ohio	214	45	15	-	5,959	5,456	119	80	34	-	35	18
Ind.	117	15	1	-	2,094	2,550	131	94	-	2	5	3
Ill.	403	15	3	-	6,934	6,658	52	7	1	-	1	-
Mich.	249	61	12	3	2,409	5,566	33	147	3	5	15	-
Wis.	49	3	1	-	615	1,617	120	76	7	-	1	-
W.N. CENTRAL	333	62	3	4	5,665	6,556	422	182	71	4	10	7
Minn.	35	3	1	-	704	696	139	8	2	1	-	-
Iowa	19	15	-	2	431	454	9	9	-	-	2	6
Mo.	189	19	-	-	3,350	4,125	92	146	67	3	1	-
N. Dak.	-	1	-	-	-	16	15	1	-	-	1	-
S. Dak.	2	2	-	1	47	101	102	-	-	-	-	-
Nebr.	14	5	-	1	3	404	28	9	-	-	6	1
Kans.	74	17	2	-	1,130	760	37	9	2	-	-	-
S. ATLANTIC	2,644	216	22	7	43,303	39,046	239	567	62	16	47	38
Del.	27	8	3	-	373	540	5	52	-	1	5	15
Md.	277	36	6	-	3,822	3,907	54	97	9	5	6	5
D.C.	187	3	-	-	1,959	2,578	4	32	-	-	6	-
Va.	177	47	3	2	4,648	3,571	26	47	6	4	5	14
W. Va.	18	-	1	-	202	295	2	17	-	3	-	1
N.C.	134	32	8	-	5,357	7,645	18	97	27	-	9	1
S.C.	119	5	-	-	2,607	2,836	9	13	-	-	12	-
Ga.	343	18	-	-	13,493	10,020	23	71	5	-	-	-
Fla.	1,362	67	1	5	10,842	7,654	98	141	15	3	4	2
E.S. CENTRAL	372	61	4	-	10,779	11,845	60	250	254	-	13	12
Ky.	36	34	3	-	1,029	1,256	19	25	-	-	7	6
Tenn.	115	10	-	-	3,247	4,330	26	197	250	-	5	6
Ala.	169	13	-	-	3,866	3,245	6	28	4	-	1	-
Miss.	52	4	1	-	2,637	3,014	9	-	-	-	-	-
W.S. CENTRAL	1,009	38	4	1	10,972	13,839	207	202	12	17	2	6
Ark.	44	7	1	-	2,098	1,718	22	22	1	-	-	1
La.	221	4	-	-	1,666	3,082	22	32	-	1	-	-
Okla.	43	-	1	1	1,216	1,477	53	52	10	2	2	5
Tex.	701	27	2	-	5,992	7,562	110	96	1	14	-	-
MOUNTAIN	335	25	4	1	2,280	2,742	523	140	38	18	20	-
Mont.	2	-	1	-	18	19	24	13	4	-	2	-
Idaho	7	1	-	-	28	37	14	20	1	-	1	-
Wyo.	1	-	-	-	9	31	-	2	5	-	1	-
Colo.	131	8	1	1	750	755	135	31	11	11	1	-
N. Mex.	33	5	2	-	217	260	44	23	1	3	1	-
Ariz.	88	8	-	-	777	1,059	247	20	8	1	10	-
Utah	24	-	-	-	45	89	37	1	4	3	-	-
Nev.	49	3	-	-	436	492	22	30	4	-	4	-
PACIFIC	2,882	214	22	2	10,184	12,577	1,307	727	144	50	23	36
Wash.	106	-	-	-	945	1,077	120	51	20	1	2	-
Oreg.	71	-	-	-	369	441	88	62	17	1	-	-
Calif.	2,658	183	19	1	8,474	10,683	1,064	611	106	47	20	36
Alaska	6	2	3	-	182	184	4	2	1	1	-	-
Hawaii	41	29	-	1	214	192	31	1	-	-	1	-
Guam	-	-	-	-	34	-	3	-	-	2	-	1
P.R.	109	36	-	-	15	121	4	52	1	3	1	-
V.I.	2	-	-	-	26	151	5	2	-	-	-	-
Amer. Samoa	-	-	-	-	10	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	22	2	-	-	-	-	-	-

N: Not notifiable

U: Unavailable

C.N.M.I.: Commonwealth of the Northern Mariana Islands

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending March 21, 1992, and March 23, 1991 (12th Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin- gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total		1992	Cum. 1992	1992	Cum. 1992	Cum. 1991	1992	Cum. 1992	Cum. 1991
		1992	Cum. 1992	1992	Cum. 1992	Cum. 1991									
UNITED STATES	146	21	213	3	28	1,744	579	82	638	31	252	501	2	36	205
NEW ENGLAND	3	-	2	-	5	6	39	-	-	6	25	50	-	4	1
Maine	-	-	-	-	-	-	3	-	-	1	2	-	-	-	-
N.H.	-	-	-	-	-	-	2	-	-	-	8	11	-	-	1
Vt.	-	-	-	-	-	3	1	-	-	-	-	1	-	-	-
Mass.	3	-	2	-	3	-	18	-	-	5	15	36	-	-	-
R.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	4	-
Conn.	-	-	-	-	2	3	15	-	-	-	-	2	-	-	-
MID. ATLANTIC	43	-	56	3	6	965	52	9	47	6	38	60	1	3	128
Upstate N.Y.	7	-	-	-	1	29	25	3	21	-	16	34	1	2	121
N.Y. City	22	-	22	-	1	100	2	-	4	-	-	-	-	-	-
N.J.	10	-	33	-	1	395	12	-	7	-	8	3	-	1	-
Pa.	4	-	1	3 [§]	3	441	13	6	15	6	14	23	-	-	7
E.N. CENTRAL	6	1	3	-	2	46	90	2	66	-	19	100	-	5	7
Ohio	1	-	2	-	1	1	21	-	22	-	5	24	-	-	-
Ind.	1	1	1	-	-	-	3	-	3	-	7	19	-	-	1
Ill.	1	-	-	-	-	24	39	-	21	-	3	26	-	5	3
Mich.	2	-	-	-	-	18	23	2	18	-	1	18	-	-	3
Wis.	1	-	-	-	1	3	4	-	2	-	3	13	-	-	-
W.N. CENTRAL	9	-	5	-	-	4	27	1	16	-	19	42	-	1	3
Minn.	3	-	3	-	-	2	5	-	1	-	2	16	-	-	2
Iowa	2	-	-	-	-	1	3	1	4	-	1	4	-	-	-
Mo.	3	-	1	-	-	-	7	-	9	-	11	15	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	-	-	2	1	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-
Nebr.	-	-	-	-	-	-	3	-	1	-	2	4	-	-	-
Kans.	1	-	1	-	-	1	9	-	1	-	-	1	-	1	-
S. ATLANTIC	32	16	48	-	3	123	114	29	317	6	37	31	-	3	-
Del.	1	-	-	-	-	8	2	-	-	-	-	-	-	-	-
Md.	12	-	1	-	2	34	11	1	29	3	14	5	-	-	-
D.C.	2	-	-	-	-	-	-	-	2	-	-	-	-	1	-
Va.	6	-	4	-	1	9	19	-	18	-	2	4	-	-	-
W. Va.	-	-	-	-	-	-	10	1	11	-	-	6	-	-	-
N.C.	4	6	9	-	-	-	22	21	68	-	6	7	-	-	-
S.C.	-	-	-	-	-	12	10	4	42	2	8	-	-	-	-
Ga.	2	-	-	-	-	-	13	-	18	-	2	6	-	-	-
Fla.	5	10	34	-	-	60	27	2	129	1	5	3	-	2	-
E.S. CENTRAL	4	-	65	-	1	4	50	-	18	-	2	14	-	2	-
Ky.	-	-	65	-	-	-	23	-	-	-	-	-	-	-	-
Tenn.	1	-	-	-	1	4	12	-	12	-	-	8	-	2	-
Ala.	3	-	-	-	-	-	15	-	4	-	2	6	-	-	-
Miss.	-	-	-	-	-	-	-	-	2	-	-	-	-	-	-
W.S. CENTRAL	2	-	-	-	-	5	26	27	70	-	8	12	-	-	1
Ark.	-	-	-	-	-	5	8	-	4	-	3	-	-	-	1
La.	-	-	-	-	-	-	4	1	6	-	-	7	-	-	-
Okla.	2	-	-	-	-	-	6	-	1	-	5	5	-	-	-
Tex.	-	-	-	-	-	-	8	26	59	-	-	-	-	-	-
MOUNTAIN	8	-	1	-	-	115	28	5	30	7	34	74	-	-	2
Mont.	-	-	-	-	-	-	3	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	1	5	-	1	4	8	14	-	-	-
Wyo.	-	-	1	-	-	-	2	-	-	-	-	3	-	-	-
Colo.	5	-	-	-	-	1	5	1	4	2	12	27	-	-	-
N. Mex.	2	-	-	-	-	76	2	N	N	-	9	12	-	-	1
Ariz.	1	-	-	-	-	26	5	4	19	-	-	8	-	-	-
Utah	-	-	-	-	-	4	1	-	3	1	5	10	-	-	-
Nev.	-	-	-	-	-	7	5	-	3	-	-	-	-	-	1
PACIFIC	39	4	33	-	11	476	153	9	74	6	70	118	1	18	63
Wash.	1	-	-	-	7	-	23	1	4	3	12	19	-	-	-
Oreg.	4	-	1	-	-	5	27	N	N	-	5	20	-	1	-
Calif.	31	4	24	-	3	469	96	8	68	3	49	55	1	15	62
Alaska	-	-	8	-	1	-	3	-	-	-	-	5	-	-	-
Hawaii	3	-	-	-	-	2	4	-	2	-	4	19	-	2	1
Guam	-	U	1	U	3	-	-	U	2	U	-	-	U	-	-
P.R.	-	-	5	-	-	1	2	-	-	1	3	6	-	-	-
V.I.	-	-	-	-	-	1	-	-	8	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	1	25	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

*For measles only, imported cases include both out-of-state and international importations.

N: Not notifiable U: Unavailable ¹International [§]Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending March 21, 1992, and March 23, 1991 (12th Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic- shock Syndrome	Tuberculosis		Tula- remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1991	Cum. 1992	Cum. 1992	Cum. 1992	Cum. 1992
UNITED STATES	7,878	9,395	64	3,688	4,196	15	58	23	1,470
NEW ENGLAND	147	254	4	66	117	-	9	2	151
Maine	-	-	-	18	16	-	-	-	-
N.H.	-	2	3	-	-	-	-	-	-
Vt.	-	1	-	-	1	-	-	-	-
Mass.	61	126	1	30	46	-	6	1	-
R.I.	13	12	-	-	16	-	-	1	-
Conn.	73	113	-	18	38	-	3	-	151
MID. ATLANTIC	1,055	1,654	9	711	1,001	-	18	-	430
Upstate N.Y.	62	103	3	-	69	-	3	-	300
N.Y. City	595	818	-	509	653	-	4	-	-
N.J.	54	270	-	43	182	-	9	-	70
Pa.	344	463	6	159	97	-	2	-	60
E.N. CENTRAL	957	891	19	368	494	-	2	3	22
Ohio	151	129	6	73	77	-	1	3	1
Ind.	64	23	2	38	27	-	-	-	-
Ill.	489	391	3	205	278	-	-	-	4
Mich.	120	227	8	36	83	-	1	-	1
Wis.	133	121	-	16	29	-	-	-	16
W.N. CENTRAL	291	174	7	76	118	2	-	1	296
Minn.	21	19	2	21	19	-	-	-	96
Iowa	6	18	3	6	21	-	-	-	33
Mo.	217	98	-	32	43	2	-	1	2
N. Dak.	-	-	1	1	3	-	-	-	14
S. Dak.	-	1	-	8	11	-	-	-	15
Nebr.	1	1	1	1	3	-	-	-	2
Kans.	46	37	-	7	18	-	-	-	134
S. ATLANTIC	2,331	2,977	7	791	661	3	5	12	328
Del.	50	31	1	5	7	-	-	-	59
Md.	182	257	1	67	58	2	1	-	123
D.C.	123	155	-	34	40	-	1	-	5
Va.	155	253	1	91	62	1	-	-	42
W. Va.	5	4	-	15	22	-	1	-	9
N.C.	555	448	2	112	90	-	-	10	1
S.C.	289	365	1	81	75	-	-	-	25
Ga.	509	732	-	162	131	-	-	-	59
Fla.	463	732	1	224	176	-	2	2	5
E.S. CENTRAL	1,254	1,029	-	214	360	5	-	-	24
Ky.	31	18	-	77	72	2	-	-	13
Tenn.	269	385	-	4	119	3	-	-	-
Ala.	635	365	-	100	94	-	-	-	11
Miss.	319	261	-	33	75	-	-	-	-
W.S. CENTRAL	1,387	1,522	-	275	362	5	1	3	87
Ark.	229	69	-	26	40	2	-	2	9
La.	571	544	-	8	20	-	-	-	-
Okla.	67	36	-	25	15	3	-	1	63
Tex.	520	873	-	216	287	-	1	-	15
MOUNTAIN	111	119	5	103	113	-	1	1	23
Mont.	2	1	-	-	-	-	-	-	1
Idaho	1	3	1	7	2	-	1	-	-
Wyo.	-	1	-	-	1	-	-	-	10
Colo.	18	21	2	5	6	-	-	-	-
N. Mex.	11	6	-	14	5	-	-	-	-
Ariz.	44	84	1	53	73	-	-	-	12
Utah	1	3	1	6	13	-	-	1	-
Nev.	34	-	-	18	13	-	-	-	-
PACIFIC	345	775	13	1,084	970	-	22	1	109
Wash.	20	40	-	51	59	-	2	-	-
Oreg.	13	24	-	22	15	-	-	-	-
Calif.	305	708	13	980	828	-	19	1	101
Alaska	1	2	-	12	20	-	-	-	8
Hawaii	6	1	-	19	48	-	1	-	-
Guam	1	-	-	10	-	-	-	-	-
P.R.	40	84	-	40	38	-	-	-	11
V.I.	15	26	-	1	1	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-
C.N.M.I.	2	-	-	8	4	-	-	-	-

U: Unavailable

**TABLE III. Deaths in 121 U.S. cities,* week ending
March 21, 1992 (12th Week)**

Reporting Area	All Causes, By Age (Years)					P&I†	Total‡	Reporting Area	All Causes, By Age (Years)					P&I†	Total‡
	All Ages	≥65	45-64	25-44	1-24				<1	All Ages	≥65	45-64	25-44		
NEW ENGLAND	614	433	93	53	13	22	44	S. ATLANTIC	1,396	830	259	190	67	49	66
Boston, Mass.	179	98	38	27	6	10	16	Atlanta, Ga.	171	89	-	50	20	12	5
Bridgeport, Conn.	45	31	7	4	-	3	1	Baltimore, Md.	207	113	49	28	7	10	19
Cambridge, Mass.	22	20	1	-	-	1	-	Charlotte, N.C.	106	65	19	13	4	5	1
Fall River, Mass.	21	20	-	1	-	-	2	Jacksonville, Fla.	123	83	26	8	5	1	9
Hartford, Conn.	49	38	5	2	1	3	1	Miami, Fla.	148	60	38	37	7	6	-
Lowell, Mass.	23	21	2	-	-	-	-	Norfolk, Va.	58	38	7	5	5	3	6
Lynn, Mass.	14	11	-	1	1	1	-	Richmond, Va.	83	53	19	8	3	-	5
New Bedford, Mass.	19	15	2	2	-	-	-	Savannah, Ga.	46	35	6	1	3	1	3
New Haven, Conn.	37	22	5	7	2	1	2	St. Petersburg, Fla.	71	55	9	3	1	3	3
Providence, R.I.	29	23	2	4	-	-	3	Tampa, Fla.	210	142	46	15	3	4	9
Somerville, Mass.	4	4	-	-	-	-	-	Washington, D.C.	151	82	34	22	9	4	6
Springfield, Mass.	60	42	14	2	1	1	5	Wilmington, Del.	22	15	6	-	-	-	-
Waterbury, Conn.	44	32	7	3	2	-	6	E.S. CENTRAL	811	528	153	79	24	27	54
Worcester, Mass.	68	56	10	-	-	2	8	Birmingham, Ala.	122	81	22	11	5	3	5
MID. ATLANTIC	2,700	1,779	504	285	63	68	150	Chattanooga, Tenn.	66	46	12	6	2	-	7
Albany, N.Y.	47	34	5	4	3	1	5	Knoxville, Tenn.	81	49	12	11	2	7	13
Allentown, Pa.	25	19	5	1	-	2	2	Louisville, Ky.	80	56	12	5	1	6	5
Buffalo, N.Y.	117	81	26	5	4	1	6	Memphis, Tenn.	172	103	40	24	5	-	12
Camden, N.J.	36	22	6	3	2	3	-	Mobile, Ala.	113	77	18	9	2	7	2
Elizabeth, N.J.	29	21	4	4	-	-	-	Montgomery, Ala.	48	32	9	3	4	-	2
Erie, Pa.§	52	42	6	1	3	-	3	Nashville, Tenn.	129	84	28	10	3	4	8
Jersey City, N.J.	45	31	5	7	-	1	4	W.S. CENTRAL	1,309	802	306	140	37	24	92
New York City, N.Y.	1,313	795	274	183	28	33	60	Austin, Tex.	65	42	13	7	2	1	6
Newark, N.J.	50	21	10	13	2	4	4	Baton Rouge, La.	48	32	10	5	1	-	7
Paterson, N.J.	22	14	6	1	1	-	-	Corpus Christi, Tex.	U	U	U	U	U	U	U
Philadelphia, Pa.	496	358	76	40	11	11	26	Dallas, Tex.	206	106	63	26	7	4	6
Pittsburgh, Pa.§	72	50	13	4	4	4	5	El Paso, Tex.	83	53	15	9	3	3	6
Reading, Pa.	38	32	2	4	-	-	10	Ft. Worth, Tex.	95	60	15	14	3	3	9
Rochester, N.Y.	132	88	33	6	3	2	5	Houston, Tex.	221	124	60	26	7	4	19
Schenectady, N.Y.	21	19	2	-	-	-	1	Little Rock, Ark.	73	50	13	7	1	2	5
Scranton, Pa.§	35	30	3	1	-	1	3	New Orleans, La.	109	63	31	11	2	2	-
Syracuse, N.Y.	86	63	12	4	1	6	2	San Antonio, Tex.	201	129	43	18	7	4	20
Trenton, N.J.	36	24	6	5	-	1	8	Shreveport, La.	101	71	18	10	2	-	13
Utica, N.Y.	25	17	6	2	-	-	1	Tulsa, Okla.	107	72	25	7	2	1	1
Yonkers, N.Y.	23	18	4	-	1	-	5	MOUNTAIN	827	557	149	76	22	23	58
E.N. CENTRAL	2,218	1,414	448	206	90	60	123	Albuquerque, N.M.	83	59	12	7	3	2	1
Akron, Ohio	53	38	11	1	1	2	-	Colo. Springs, Colo.	52	30	12	5	1	4	6
Canton, Ohio	39	30	7	1	-	1	4	Denver, Colo.	125	76	24	15	4	6	20
Chicago, Ill.	436	180	95	100	49	12	11	Las Vegas, Nev.	122	80	26	12	3	1	4
Cincinnati, Ohio	171	118	34	11	6	2	19	Ogden, Utah	16	12	2	2	-	-	2
Cleveland, Ohio	137	90	29	10	3	5	1	Phoenix, Ariz.	189	123	33	23	3	7	12
Columbus, Ohio	167	114	35	11	5	2	6	Pueblo, Colo.	17	12	4	1	-	-	2
Dayton, Ohio	106	70	28	6	1	1	8	Salt Lake City, Utah	86	63	16	4	3	-	6
Detroit, Mich.	210	122	52	18	6	12	8	Tucson, Ariz.	137	102	20	7	5	3	5
Evansville, Ind.	49	40	8	-	1	-	5	PACIFIC	1,789	1,180	319	177	68	30	133
Fort Wayne, Ind.	74	56	11	4	2	1	2	Berkeley, Calif.	24	17	5	1	-	1	1
Gary, Ind.	21	8	7	5	-	1	-	Fresno, Calif.	74	48	16	5	3	2	7
Grand Rapids, Mich.	67	53	9	3	1	1	10	Glendale, Calif.	26	25	-	-	1	-	2
Indianapolis, Ind.	219	143	47	15	7	7	8	Honolulu, Hawaii	76	42	24	4	3	3	4
Madison, Wis.	33	26	3	2	-	2	5	Long Beach, Calif.	78	55	17	5	1	-	9
Milwaukee, Wis.	120	89	22	4	1	4	11	Los Angeles, Calif.	405	237	69	62	20	3	18
Peoria, Ill.	41	32	7	-	-	2	4	Pasadena, Calif.	30	19	5	2	1	3	4
Rockford, Ill.	53	39	7	5	2	-	10	Portland, Oreg.	137	103	21	7	4	2	9
South Bend, Ind.	56	37	11	4	1	3	-	Sacramento, Calif.	135	81	31	13	5	5	14
Toledo, Ohio	103	82	12	5	3	1	11	San Diego, Calif.	160	101	31	15	8	4	19
Youngstown, Ohio	63	47	13	1	1	1	-	San Francisco, Calif.	145	76	33	26	7	3	4
W.N. CENTRAL	733	510	134	50	16	23	43	San Jose, Calif.	178	132	25	11	8	2	18
Des Moines, Iowa	70	55	9	5	1	-	4	Santa Cruz, Calif.	27	23	1	-	3	-	2
Duluth, Minn.	23	16	5	2	-	-	-	Seattle, Wash.	160	118	23	16	2	1	4
Kansas City, Kans.	16	6	7	1	1	1	1	Spokane, Wash.	52	42	7	2	1	-	7
Kansas City, Mo.	83	58	18	5	1	1	2	Tacoma, Wash.	82	61	11	8	1	1	11
Lincoln, Nebr.	42	34	5	2	-	1	1	TOTAL	12,397†	8,033	2,365	1,256	400	326	763
Minneapolis, Minn.	181	119	46	11	4	1	11								
Omaha, Nebr.	84	52	14	7	4	7	8								
St. Louis, Mo.	115	87	15	9	1	3	10								
St. Paul, Minn.	52	39	6	1	2	4	5								
Wichita, Kans.	67	44	9	7	2	5	1								

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

‡Because of changes in reporting methods in these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

§Total includes unknown ages.

U: Unavailable

Human T-Lymphotropic Virus Type II Among Guaymi Indians – Panama

Human T-lymphotropic virus type 2 (HTLV-II) is one of four retroviruses (i.e., HTLV-I, human immunodeficiency virus type 1 [HIV-1], and HIV-2) that are known to infect humans. During 1988, investigators from the Gorgas Memorial Laboratory (GML) and the National Institutes of Health (NIH) tested serum specimens collected during 1978–1987 throughout Panama to determine the prevalence of HTLV-I infection (1), which is endemic in southern Japan and the Caribbean basin (2). HTLV seropositivity rates were low in all areas of Panama except among the Guaymi Indians in Changuinola (9%)* a city in western Panama (Figure 1). During 1989–1991, additional testing of 36 seropositive specimens from Guaymi Indians detected that the infections were due to HTLV-II (3,4). This report summarizes risk factor data for HTLV-II infection among Guaymi Indians.

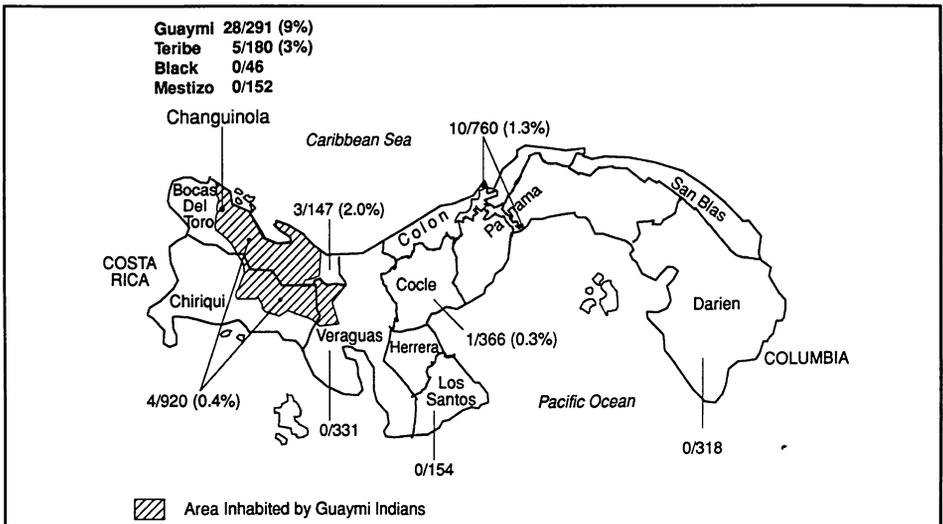
During December 1989–March 1990, Guaymi households were randomly selected and contacted for a cross-sectional study to determine risk factors for HTLV-II infection. Serum was collected from 254 persons aged ≥ 1 year for whom consent was obtained, and risk data (i.e., sexual behavior and history of injection) were collected from participants aged ≥ 7 years.

The median age of participants was 16 years (range: 1–72 years); 140 (55%) were male. Although none of 59 participants aged < 7 years tested HTLV-antibody-positive, 17 (9%) of 195 persons aged ≥ 7 years tested HTLV-I/II-antibody-positive; all were confirmed by additional testing to be infected with HTLV-II.

Seropositivity rates increased with age and were highest (15%) for those aged > 30 years. Although no other association reached statistical significance, infected

*Among other populations in Changuinola, HTLV I/II infection was low or nonexistent (i.e., Teribe Indians [5/180, 3%], Mestizos [0/152], and blacks [0/46]).

FIGURE 1. Prevalence rates of antibody to HTLV-I/II – Panama, 1978–1987*



*Serum specimens were collected during 1978–1987 and analyzed in 1988.

HTLV-II – Continued

persons were more likely to report a history of one or more marriages (odds ratio [OR]=3.2; $p=0.1$), cohabitation with one or more partners (OR=2.1; $p=0.3$), one or more lifetime sex partners (OR=2.0; $p=0.4$), and to be seropositive for herpes simplex virus type 2 (OR=2.1; $p=0.2$). HTLV-II infection was not associated with histories of blood transfusion, vaccination, injection, or tattoo.

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Editorial Note: HTLV-II has primarily been associated with injecting-drug users (IDUs) and their sex partners (5). In the United States, the initiation of volunteer blood-donor screening for HTLV infection in November 1988 resulted in the identification of approximately 2000 seropositive units of blood donated each year. Of these, at least half were infected with HTLV-II (6).

The Guaymi in Changuinola, who have migrated from traditional living areas in the mountains of western Panama, are the first nondrug-injecting population known to have high rates of HTLV-II infection. Associations of HTLV-II infection with other Native American Indian groups have been reported but not confirmed by population-based studies (7).

HTLV-I and HTLV-II are closely related (60% genomic homology) and, like the immunodeficiency viruses, have a tropism predominantly for CD4 lymphocytes and infect the human host for life. Serologic tests for HTLV-I, including enzyme immunoassay, Western blot, and radioimmunoprecipitation assay, also detect HTLV-II through cross-reactivity. Therefore, seropositive results are properly referred to as HTLV-positive or HTLV-I/II-positive, and not as HTLV-I-positive as is sometimes reported. Further discrimination between HTLV-I and HTLV-II requires additional testing with techniques such as polymerase chain reaction or newly developed HTLV type-specific peptide serologic assays. HTLV serologic tests do not cross-react with HIV.

Notification and counseling of infected persons has been difficult because of the lack of information concerning disease risk and transmission. HTLV-II has not been linked with disease. However, because as many as 5% of persons infected with HTLV-I have developed adult T-cell leukemia/lymphoma or HTLV-I-associated myelopathy/tropical spastic paraparesis (8), there is concern about possible disease associations with HTLV-II infection.

Similarly, the modes of transmission of HTLV-II are not well documented. Both HTLV-I and HTLV-II are highly cell associated, and transmission of either virus is thought to require passage of infected lymphocytes, rather than cell-free body fluids. Within areas endemic for HTLV-I, breastfeeding, sex, and transfusion of infected cellular blood products have transmitted HTLV-I (8).

Preliminary findings among the Guaymi suggest that there may be important differences between HTLV-I and HTLV-II transmission; for example, despite the universal practice of breastfeeding among the Guaymi, lack of seropositivity among young Guaymi children suggests that HTLV-II may not be efficiently passed by this route. In contrast, preliminary data suggest that sexual contact may be the most important route of transmission in this population.

To resolve these issues and to obtain data that may be difficult to acquire from other populations, investigators from the GML, the NIH, and CDC began pilot studies during November 1991 in preparation for a three-part study of HTLV-II infection

HTLV-II – Continued

among Guaymi Indians. Phase I, in which approximately 5000 persons are expected to be enrolled, is a cross-sectional serosurvey of all Guaymi in Changuinola aged ≥ 1 year. In phase II, persons identified as infected with HTLV-II in phase I will be compared with seronegative controls to assess differences in risk behaviors, diseases, and laboratory-measured immunologic parameters possibly associated with HTLV-II. Phase III will be a hospital-based study to identify possible disease associations; HTLV-II infection rates among Guaymi patients will be compared with rates in the general Guaymi population.

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Availability of Computerized Health Information Database from World Health Organization, European Region

As part of the international objectives for health for all by the year 2000 (HFA) (1,2), the World Health Organization, European Region (WHO-Europe) developed 38 specific regional HFA targets for that region (3). To monitor progress toward this strategy, WHO-Europe has developed several health-related statistical and textual databases that provide information from the 32 European member states.

The databases are being further developed and adapted with member states to make them more relevant to their users. They allow rapid retrieval of information by each regional objective, as well as by keywords and subject area. The following databases are currently available: *Statistical*—Health for All Indicator Database, Food and Health Indicator Database, and AIDS Surveillance Database; *Textual*—Health Legislation Database and Documentation Retrieval Database. All can be accessed through on-line telecommunications.

Additional information is available from WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen, Denmark; telephone 45 39 17 17 17; telex 15 348 who dk; fax 45 31 18 11 20.

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